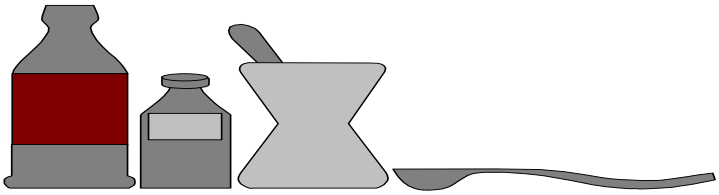

MEDI-CAL DRUG USE REVIEW BOARD

Jude Simon-Leack
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MAY 2003 DUR BOARD MINUTES

Roll Call and Guests: First Item: Called to order Ms Janeen McBride (10:10) present: Dr Wong, Dr McCart, Dr Stahl on the phone, Dr. Richard Morita, Dr. Kevin Gorospe Melisa Mulcahy, Keli Griffith, Dr Ron Sanui,

Approval of Minutes: Motion to approve as written (Dr Wong). No discussion. Approved unanimously.

Operational issues: Lunch courtesy of Pfizer, Inc following Board meeting in same room,

Status of Annual Report: CMS efforts to prepare a revised reporting format will not be completed in time for the 2002 report. CMS has advised using the earlier reporting format for the FY 2001. This late notice has caused a delay in preparation of the annual report and it will not be ready for review until the end of May. At this time, a rough draft will be distributed and the Board asked to vote on approval. The final document must be sent to CMS no later than June 30, 2003.

Redesign of the Target Drug List: The redesign of the Target Drug List is based on the development of therapeutic categories, which is a new approach to conceptualize the work of the Board, and will influence many DUR activities.

The completion and submission of a State audit of Medi-Cal provided information that makes it necessary for the Board to delay finalizing of the Therapeutic Category Target Drug List until a future meeting. As the Department implements newer activities, the DUR Board should consider the audit findings as it proceeds forward in developing the DUR program. The audit was commissioned by the State Legislature and prepared by the Bureau of State Audits a copy of this audit was sent out to the Board for discussion and we will use this document as the basis for a discussion of disease management and DUR.

A summary of the audit's relevance to DUR was provided by Dr Gorospe. He noted that disease management, including tools such as step therapy, is seen as an approach that can control costs. DUR will play a major role in this activity. Additionally, the use of "Dear Doctor" letters addressing outlier

prescribers in one format or another is being considered. No mention was made of restricting the number of drugs in a therapeutic class. There was recommendation to turn some of the DUR alerts from soft to hard edits. A more formal plan of education was also recommended. Dr Gorospe said that the Board needs to come up with a consolidated plan (mission) and direction of activity. Disease Management activity should have a more defined structure and identifiable steps. Of course, all this depends on the budget!

Dr Simon-Leack returned to the discussion of organizing the Board's work. He noted that, up to this point, we have been resource-driven. He asked Dr Stahl for an update. New York Times interviewed Dr Stahl regarding the Atypical Antipsychotic project and it is clear we have a leadership role at the national level. The need is to find out if what we do is working. Can our efforts be a real alternative to formulary restrictions? Dr Simon-Leack noted that he and Mr. Walker presented at a national DUR conference, CPhA published a thumbnail of the Atypicals project. Also, Walgreens expressed interest in putting this on their intranet.

Disease Management/Project Update Discussion (Attachment 1). The DUR Board's approach to DUR activities in the past has been to select projects individually (e.g. diabetes, hypertension, etc.), pull down data, come to some conclusions, educate and then move on to the next program. This is somewhat wasteful of resources and projects are rarely related to one another, even though the same beneficiaries may reappear in multiple studies due to co-morbidities. Dr. Simon-Leack noted that the newer thinking is to develop programs that evaluate the role of multiple disease states as an integrated whole. Instead of a separate diabetes program, the Board would look at diabetes as it relates to the atypical population, the arthritis, asthma and antibiotic receiving patients. The advantage of this approach is it is true to the real world; people don't suffer diseases in a vacuum but many times suffer from multiple diseases that can be interrelated. Another advantage is resources can be pooled and more effectively used. Also, the amount of redundant data downloading and crunching is considerably reduced and the findings are available more quickly. The likelihood of changing behavior in beneficiaries is greater since the Board would be addressing more of their total experience.

Dr Simon-Leack noted that current DUR projects are on the brink of drawing down data for a number of activities. The Board may want to consider adding a few more data elements (ICD9 codes for diabetes in the schizophrenia population, pain medication in the arthritis population, etc.) to each query so that a link can be made to co-morbidities. AWARE is a good example as they involve multiple private insurers and plan to draw down three years of data that will essentially represent most of California! Why not add a field for co-morbidities and expand the use of this data to other projects?

Dr Wong continued with an update of the arthritis project, noting that setting up databases and overall plan before beginning the studies will produce a very solid foundation for quality programs. He noted that Medi-Cal has a good database for encounter data/claims data and there is a need to integrate outcomes information into this database. He commented that an increasingly popular format in outcomes is patient self-report data. This would be especially pertinent to the Medi-Cal population where the medical record alone does not fully reflect the status of the patient. Developing a system where the Medi-Cal population is surveyed or otherwise engaged to self-report could be the basis for newer approaches to developing a database. The patients could be periodically resurveyed and this data cross-linked to all disease states. He is doing this with arthritis, having been the first to collect this type of outcomes data in LA County. He did develop a proposal for national funding through the Arthritis

Foundation. The proposal was ranked third of all proposals but the initial plan of funding the top four was reduced to funding only one. Importantly, the high ranking of this proposal illustrates that the concept and direction are solid and consistent with national priorities. A strong point of agreement nationally is the importance of studying the Medicaid data. He distributed an executive summary of the proposal to the Board. Mr. Walker has given Dr Wong a preliminary data draw of LA County and is waiting for a second data draw. Mr. Walker noted that as we are in the data phase, the next step would be to run this through the State Protection of Human Subjects Committee. He also noted that there is a need for some additional signed agreement of confidentiality.

Dr McCart asked how outcomes can be addressed in regards to the privacy. Mr. Walker replied that the previous meeting with Dr Dickey made considerable progress in resolving this. There is an equivalent IRB process at the State level similar to what universities currently operate under. It will be necessary for all projects to go through this (some may be expedited) even if they have also gone through an IRB at the university. Dr Wong noted that if we do not have direct patient contact but go through a questionnaire or survey, this would qualify for an expedited review.

Dr Simon-Leack went on to discuss the asthma project in Dr Jones' absence. This project also involves integrating medical record data with claims data with the intent of defining markers or predictors of well-being or disease.

Discussion moved to steps required to meet all legal requirements for use of Medi-Cal data. Mr. Walker noted that if the intent is to publish (generalized knowledge), this must go through the State Protection of Human Subjects Committee. This means we need to get AWARE involved in this State Committee. Dr Simon-Leack restated the need for a larger plan, organized approach and novel ideas.

Long Term Care summary – update notes that USC is interested in supporting the LTC and geriatrics activities. This is being developed by the LTC subcommittee of CPhA. They are also interested in reviewing First DataBank (FDB) data and possibly supporting a geriatrics dosing module.

Pain Management – this activity is driven somewhat by the Department of Justice (DOJ), but is not entirely punitive in its intent. Rather the goal is to develop a standard of practice and to assist prescribers in understanding the best way to use these drugs. This standard could then be used to identify outlying prescibers. Dr Stahl announced that his Neuroscience Education Institute, along with the University of California, San Diego, is going to host a psychopharmacology congress. It will start in March in 2004 and will have a pain module. All physicians in California must have 12 hours of pain-related continuing medical education by 2006 to keep their licenses current. It would help Dr Stahl if we could have the DUR imprimatur – maybe an algorithm of best practices could be available for this congress. If this year is too soon, maybe later on. Dr Stahl asked Dr Simon-Leack would be available for a lecture.

Diabetes – Dr Simon-Leack introduced this topic, and Dr Stahl felt the best way to integrate this into DUR Board work would be to do this as a spin-off of the atypicals project. The issue of the metabolic syndrome related to the use of atypicals is gaining significance. There would be corporate interest but it might be divisive because there would be winners and losers. Dr Gorospe recommended that Dr Simon-Leack contact Dr. Michael Negretti at CPhA, as they are preparing to launch a pharmacist-based disease management program pilot project in San Diego. Dr Simon-Leack added that FDB is looking at building a pharmacogenomics module.

Exception Tables - Dr Simon-Leack opened discussion of exception tables. These are tables created by our DUR board and maintained only by the Board, not FDB, to override FDB information with more focused information or more desirable information. The Board needs to review these tables and decide whether to keep, change or delete them. This is just an announcement of an upcoming discussion. A comparison of today's facts with those in the tables will be brought to the next meeting for discussion. Mr. Walker expressed concern that we should not delete the tables because we might need them in the future. Dr Simon-Leack noted that this should not be a concern as FDB has been very responsive to our needs in DUR. Dr Morita noted that there are supposed to be reports to the Board of updates quarterly but this has not occurred. Dr Simon-Leack noted there has not been information worth reporting but agrees to bring this data to the board review.

He went on to say that he hopes that future DUR decision making will be from the top down. That is, we develop our mission and orientation based on the diseases we are investigating, then this information drives the development of a target drug table, a functional manual, a set of alerts designed to measure what we are interested and an on-going reporting process that tells us what we need to know. Philosophy, facts, functionality, output.

Mr. Walker discussed the State section. The audit is available on the website www.bsa.ca.gov He believes that the audit has brought out State thinking in the direction of step therapy, dear doctor letters and report cards. Mr. Walker noted that a 1989 pilot project did traditional DUR letters. The letters were found to be less than effective. The DUR Board at that time received complaints that the data in the letters was too old to be useful, e.g., often alerts were not sent to physicians until many months after the offending drug had been prescribed. Also, physicians claimed they were receiving alerts for Medi-Cal beneficiaries who were not their patients, or who had not been seen by these physicians in a long time. The outcome of the study was that it did save a modest amount of drug money, but that the administrative costs of the program were greater than the savings generated. Mr. Walker thinks that, with some help from the Board, a better design might be developed. He asked Ms McBride about whether she uses physician letters in her organization. She noted that most managed medication programs do this automatically – the letters are generated and faxed by the computer to the doctor within a day. The doctor has to check, sign and fax back to the system with his response to the information. Dr. Sanui added that many managed care programs in the state have ongoing quality assurance programs with a substantial level of sophistication. These programs can involve entering patients into a registry and maintaining this. It is hard on the physicians because they are inundated with paperwork and usually need incentive to do this. He has been working on this along with Dr. Negretti from the California Pharmacist's Association. One of Dr. Sanui's goals is to bring Medi-Cal Managed Care and Medi-Cal Fee-for-Service closer together in terms of the models of disease management. He mentioned the ongoing disease management activities include diabetes and asthma (in terms of beta agonist overuse and the need to supplement with inhaled steroids).

Dr Stahl asked how this type of program might be made operational for the DUR program, assuming an acuity adjustment could be made. Mr. Walker added that this model works well in a managed care setting where the beneficiaries are broken out into smaller groups, each served by a pharmacist, but in the fee-for-service setting, he and Dr Simon-Leack are the major personnel resources and unable to do that level of activity. Is it still possible to do this under these circumstances? Dr Sanui replied that the

centralized data base is a real asset and county mental health is one unified system that might be impacted. Dr Gorospe answered the question about whether we get data from the county mental health system, noting that if the patient is a member of fee-for-service, we have the data and if they are a member of managed care, the antipsychotics are carved out for payment in fee-for-service process and there is some encounter data also available. Physician data is also available indirectly as part of encounter data collected for their responsibility to the Department of Mental Health. This would require some interdepartmental team work. The other diseases: asthma, arthritis, diabetes, infectious disease, etc are simpler to move forward.

Discussion moved on to resources necessary to perform the above activities. The tasks that underpin the DUR program require a certain dedicated amount of time. Dr McCart noted that the seven items generated in the audit should be addressed by the Board individually. Dr Gorospe noted that before we do that, we should make sure to see the department's response to the report and the auditor's response to the response. Dr McCart noted that outsourcing is mentioned in the audit and wondered if outsourcing is one solution to this problem. Dr Gorospe noted that EDS is an outsource service and that legislative action that would be required to pursue additional outsourcing. Disease management would not necessarily reduce the spending on drugs, it may actually increase it but the overall costs of care would go down. **A MOTION** was made "The DUR program is under resourced, and could create significant cost savings mechanisms for the State if it had the resources. The State should look into resourcing DUR either through subcontracting or additional State staff."

Step therapy was discussed. Step therapy is an electronic process that screens incoming claims and turns over only those to the TAR process those that fail the step process. Mr. Walker summed up the audit results and the audit response, which discussed step care therapy, physician report cards, expanding educational projects, and prescriber interactions. More discussion will be needed as to what the Board would do if State funding became available. Dr. Stahl noted that we need to demonstrate the ability to change behavior. If we can then we are a DUR Board, if we can't then well. .Thus some project and some behavior must act as a demonstration project so to demonstrate our capacity to this – this is his recommendation as to proof of concept. Mr. Walker thought the use of pharmacists on a pilot of detailing in a specific county (a Kaiser-like concept). An academic detailing process may well play a role in a larger effort. Dr Wong suggested we change MD report cards to a different theme – such as patient/physician care report. He suggested we include the patient more openly in the process of changing process of prescribing. Dr Simon-Leack agreed that patient involvement is integral.

Mr. Walker announced that the State Department of Finance announced that the DUR Board could hold one face-to-face meeting a year, although a quarterly format may be acceptable through the use of conference calling or video conferencing. Mr. Walker suggested that perhaps meeting could be held in conjunction with other events the Board members might attend, such as CPhA or CSHP meetings. This coming fiscal year only one face-to-face meeting is authorized. Ms McBride noted at least one Board member should be at each meeting to chair because chairing from the phone is almost impossible. She would like this process explored further and Dr Stahl agreed. Dr Simon-Leack replied that the Board needs to decide what to do about September 15, all other meetings are farther in the future and circumstances could change. Mr. Walker noted the Board has authorization to meet September if we want that as our one meeting.

On-going Reports - High dose report – The DUR Board's Target Drug List only sets the high dose alert for some of the drugs on the formulary file. To test the impact of this alert on ALL drugs, the non-target drugs were turned on for the high dose alert *in test only*. This report displays the number of and percent of total test alerts of high dose alerts for a four week period for only those drugs NOT on the target list currently. Adult dosing is standard but pediatric dosing is calculated based on age and weight. The belief is that this is a self-correcting process. As the pharmacists realize that the alert is being set, they will adjust their days supply and the alert count will decline. The goal is to consider turning all formulary file drugs on for High Dose alert. (Attachment 2). Concern was expressed that no plan has been proposed to efficiently process the information received from the new alerts. If the Board doesn't have a plan to make sense of this, then what is the purpose? Also the volume of alerts may become excessively burdensome to the pharmacist. It will be more meaningful if the alert is attached only to those medications that are significant rather than by a shotgun approach.

Dr Gorospe suggested the program perform provider education on high dose alerts, specifically those drugs on the top of the list. Then rerun the test group again to see if education works.

Dr. McCart said we need more information, as the number of alerts alone doesn't give a sufficient picture of what is happening. Although he noted that the days supply impacts many of our other alerts.

ACTION: Dr Simon-Leack will bring back more detail on Vicodin and acetaminophen, and will do an educational project as well. It would probably best be done on acetaminophen.

Annual Evaluation of Top 75 Drugs- This evaluation is usually a part of the target drug list discussion, now just an information point while the Board proceeds to decide on our therapeutic categories.

Activity Summary – This summary reviews of the number and percent alerts on the attachment. (Attachment 3).

Comment – Dr. Wong suggested we expand the therapeutic class category of drugs in attachment one. For example, gabapentin is often used for pain control rather than for seizure disorders. Mr. Walker noted there was a problem with this, because FDB cannot practically assign drugs to multiple therapeutic categories.

Next meeting in new building – site to be announced.

Videoconference poll concluded that no Board members have access to videoconferencing for remote Board meetings.

Meeting adjourned at 12.

DUR AND DISEASE MANAGEMENT

The DUR Program has been expanding to include newer disease management topics. In order to plan effective use of resources, a review of the current status and intended direction is outlined below. This discussion has been touched on at previous Board meetings but there is a need to begin specific planning.

Literature has argued that disease management programs that focus on multiple chronic diseases in the same affected patients are replacing the older, first generation disease management approach of focusing on single diseases. This 'second generation' approach is due, in part, to the fact that more persons are afflicted with multiple chronic diseases than in the past. (ref)

The chart below illustrates an overview of some of the California DUR program's activity in disease management. The challenge is to build an approach, which can accommodate a growing level of activity in an effective manner.

CURRENT PROJECT ACTIVITIES - PROJECTS ARE MOSTLY STAND-ALONE				**EMERGING PROJECTS - PROPOSE INTEGRATING POPULATIONS WITH CURRENT PROJECTS**		
CURRENT PROJECT	**POPULATION**	**STATUS**		**LONG-TERM CARE - GERIATRICS - OSTEOPOROSIS**	**DIABETES - BY DIAGNOSIS**	**PAIN MANAGEMENT - BY DIAGNOSIS**
ATYPICAL ANTIPSYCHOTICS	MENTAL HEALTH - recipients of atypicals	EVALUATION OF OUTCOMES PROCEEDING		LONG-TERM CARE PTS WITH MENTAL HEALTH DIAG.	MENTAL HEALTH PATIENTS WITH DIABETES	MENTAL HEALTH PTS WITH PAIN MANAGEMENT PROBLEMS
AWARE ANTIBIOTIC OVERUTILIZATION	INCLUDED BY DIAGNOSIS ONLY	DATA PULL FOR EVALUATION BEING DESIGNED		LONG-TERM CARE PTS RECEIVING ABX	PATIENTS RECEIVING ABX AND HAVING DIABETES	PATIENTS RECEIVING ABX AND HAVING PAIN MANAGEMENT PROBLEMS
ARTHRITIS	INCLUDED BY DIAGNOSIS ONLY	DATA PULL BEGINNING		LONG-TERM CARE PTS WITH ARTHITIS	ARTHRITIS PATIENTS WITH DIABETES	ARTHRIS PATIENTS WITH PAIN MANAGEMENT PROBLEMS
ASTHMA PEDIATRICS	INCLUDED BY DIAGNOSIS AND AGE	DATA PULL BEGINNING		N/A	PEDIATIC ASTHMA PATIENTS WITH DIABETES	PEDS/ASTHMA PTS WITH PAIN MANAGEMENT PROBLEMS
LONG TERM CARE	GERIATRIC/ LONG TERM CARE POPULATION	UNDER REDESIGN - SEE EMERGING PROJECTS		N/A	GERIATRIC/LTC PATIENTS WITH DIABETES	GERIATRIC/LTC PTS WITH PAIN MANAGEMENT PROBLEMS

MAY 2003 BOARD MEETING – MINUTES
ATTACHMENT 3b –
HIGH DOSE ALERTS SET FOR ADULT DRUGS IN TEST Top 35 Drugs by Alert Count for One Month

RANK	DRUG NAME	TOTAL HD ALERTS	PERCENT OF TOTAL
1	HYDROCODONE BIT/ACETAMINOPHEN	12,593	12.615%
2	CODEINE/PROMETHAZINE HCL	10,159	10.177%
3	METRONIDAZOLE	5,823	5.833%
4	TERCONAZOLE	5,500	5.510%
5	MICONAZOLE NITRATE	4,328	4.336%
6	D-METHORPHAN HB/PROMETH HCL	4,236	4.244%
7	ACETAMINOPHEN	3,925	3.932%
8	DOCUSATE SODIUM	3,920	3.927%
9	IPRATROPIUM BROMIDE	3,736	3.743%
10	CLOTRIMAZOLE	3,447	3.453%
11	AMLODIPINE BESYLATE/BENAZEPRIL	2,897	2.902%
12	ASPIRIN	2,500	2.504%
13	FLUTICASONE/SALMETEROL	1,891	1.894%
14	PANTOPRAZOLE SOD SESQUIHYDRATE	1,772	1.775%
15	CITALOPRAM HYDROBROMIDE	1,673	1.676%
16	CLINDAMYCIN PHOSPHATE	1,552	1.555%
17	VALSARTAN/HYDROCHLOROTHIAZIDE	1,313	1.315%
18	PHENYLEPHRINE HCL/COD/PROMETH	1,249	1.251%
19	RABEPRAZOLE SODIUM	1,057	1.059%
20	PHENYLEPHRINE HCL/PROMETH HCL	965	0.967%
21	ESOMEPRAZOLE MAG TRIHYDRATE	905	0.907%
22	MAG HYDROX/AL HYDROX/SIMETH	860	0.862%
23	PROMETHAZINE HCL	762	0.763%
24	PROCHLORPERAZINE MALEATE	627	0.628%
25	BACLOFEN	589	0.590%
26	SUCRALFATE	559	0.560%
27	CHOLESTYRAMINE/SUCROSE	509	0.510%
28	MECLIZINE HCL	502	0.503%
29	DEXAMETHASONE	460	0.461%
30	TOLTERODINE TARTRATE	457	0.458%
31	LORAZEPAM	442	0.443%
32	CETIRIZINE HCL	432	0.433%
33	LOSARTAN POTASSIUM	422	0.423%
34	NYSTATIN	406	0.407%
35	SEVELAMER HCL	386	0.387%
	Grand Total	**99,822**	

MAY 2003 BOARD MEETING – MINUTES
ATTACHMENT 3a –
PEDS HIGH DOSE ALERTS IN TEST Top 35 Drugs by Alert for One Month

RANK BY NO.	GENERIC DRUG NAME	TOTAL ALERTS	PERCENT OF TOTAL
1	ACETAMINOPHEN	4,471	18.875%
2	D-METHORPHAN HB/PROMETH HCL	3,658	15.443%
3	MOMETASONE FUROATE	1,656	6.991%
4	GUAIFENESIN/D-METHORPHAN HB	1,062	4.483%
5	FLUORIDE ION/VIT A,C&D	1,050	4.433%
6	SULFACETAMIDE SODIUM	996	4.205%
7	CODEINE/PROMETHAZINE HCL	942	3.977%
8	PHENYLEPHRINE HCL/PROMETH HCL	937	3.956%
9	SODIUM FLUORIDE	791	3.339%
10	CEFDINIR	633	2.672%
11	PHENYLEPHRINE HCL/COD/PROMETH	545	2.301%
12	NYSTATIN	509	2.149%
13	FLUTICASONE PROPIONATE	433	1.828%
14	PSEUDOEPHEDRINE HCL	427	1.803%
15	PREDNISOLONE	398	1.680%
16	FERROUS SULFATE	393	1.659%
17	LAMOTRIGINE	370	1.562%
18	TRIAMCINOLONE ACETONIDE	365	1.541%
19	BUDESONIDE	346	1.461%
20	AMPHET ASP/AMPHET/D-AMPHET	328	1.385%
21	CETIRIZINE HCL	297	1.254%
22	LORATADINE	291	1.229%
23	HYDROCODONE BIT/ACETAMINOPHEN	286	1.207%
24	HYDROXYZINE HCL	239	1.009%
25	ELECTROLYTE,ORAL	161	0.680%
26	GENTAMICIN SULFATE	159	0.671%
27	SALMETEROL XINAFOATE	150	0.633%
28	GUAIFENESIN/CODEINE PHOS	149	0.629%
29	DIPHENHYDRAMINE HCL	140	0.591%
30	DESMOPRESSIN ACETATE	120	0.507%
31	BACLOFEN	107	0.452%
32	TERCONAZOLE	102	0.431%
33	AZELASTINE HCL	76	0.321%
34	LEVALBUTEROL HCL	70	0.296%
35	FOLIC ACID	58	0.245%
	Grand Total	**23,687**	

MAY 2003 BOARD MEETING – MINUTES
ATTACHMENT 4 –

MARCH 2003 DUR ALERT ACTIVITY

STATEWIDE ELIGIBLES : 2,909,652
STATEWIDE DRUG CLAIMS : 6,908,655
STATEWIDE DUR DRUG USERS : 1,190,440
STATEWIDE DUR DRUG CLAIMS: 5,078,072

STATEWIDE DUR DRUG ALERTS: 1,268,688
STATEWIDE OVERRIDES : 880,597
STATEWIDE CANCELLATIONS : 672

THERAPEUTIC PROBLEM TYPE	NUMBER OF ALERTS	ALERTS% OF DUR DRUG ALERTS	ALERTS / 1000 DUR DRUG CLAIMS	ALERTS / 1000 DUR DRUG USERS	ALERTS / 1000 DRUG CLAIMS	ALERTS / 1000 ELIGIBLES	NUMBER OF OVERRIDES	OVERRIDES/ 1000 ALERTS	NUMBER OF CANCELS	CANCELS / 1000 ALERTS
DRUG-DRUG	8,171	.64	1.60	6.86	1.18	2.80	6,579	805.16	2	.24
HIGH DOSE-AD	56,658	4.46	11.15	47.59	8.20	19.47	39,543	697.92	20	.35
HIGH DOSE-PD	20,476	1.61	4.03	17.20	2.96	7.03	15,338	749.07	9	.43
TOTAL HD	77,134	6.07	15.18	64.79	11.16	26.50	54,881	711.50	29	.37
LOW DOSE -AD	63,173	4.97	12.44	53.06	9.14	21.71	44,038	697.10	18	.28
LOW DOSE -PD	9,000	.70	1.77	7.56	1.30	3.09	6,622	735.77	1	.11
TOTAL LD	72,173	5.68	14.21	60.62	10.44	24.80	50,660	701.92	19	.26
EARLY REFILL	380,078	29.95	74.84	319.27	55.01	130.62	215,518	567.03	351	.92
LATE REFILL	174,518	13.75	34.36	146.59	25.26	59.97	140,051	802.50	86	.49
INCORR DUR	0	0.00	0.00	0.00	0.00	0.00	0	0.00	0	0.00
DRUG-ALLERGY	812	.06	.15	.68	.11	.27	569	700.73	0	0.00
DRUG-DISEASE	30,137	2.37	5.93	25.31	4.36	10.35	23,362	775.19	0	0.00
DRUG-GENDER	0	0.00	0.00	0.00	0.00	0.00	0	0.00	0	0.00
DRUG-PREG	5,429	.42	1.06	4.56	.78	1.86	3,894	717.25	0	0.00
THERAPY DUP	278,464	21.94	54.83	233.91	40.30	95.70	203,599	731.15	93	.33
INGRED DUP	179,998	14.18	35.44	151.20	26.05	61.86	130,584	725.47	62	.34
DRUG AGE	221	.01	.04	.18	.03	.07	164	742.08	0	0.00
ADDITIVE TOX	61,553	4.85	12.12	51.70	8.90	21.15	50,736	824.26	15	.24
TOTAL	**1,268,688**						**880,597**		**672**	

*** END OF REPORT ***